FINDING: MEDICAL NECESSITY

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
Provider submitted claims for services billed as inpatient hospital services, when the documentation does not support the level of care billed.	A medically necessary service means it is required to treat a member's illness, injury or disability and is the most appropriate level of service that can safely and effectively be provided to the member. The documentation does not support inpatient hospital services as the most appropriate level of service that can safely and effectively be provided to the member. The Department of Health Services (DHS) was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 101.03(96m) § 101.03(103) § 106.02(9)(a)4 § 106.02(9)(a)5 § 106.02(9)(g) § 107.08(1)(a) § 106.02(9)e § 107.01 § 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The services provided are not medically necessary/appropriate for the condition of the member.	A medically necessary services means it is required to treat a member's illness, injury or disability and meets the following standards: 1. Is consistent with the member's symptoms or with prevention, diagnosis or treatment of the member's illness, injury or disability. 2. Is provided consistent with the standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided. 3. Is appropriate with regard to generally accepted standards of medical practice. 4. Is not medically contraindicated with regard to the member's diagnoses, the member's symptoms or other medically necessary services being provided to the member. 5. Is of proven medical value or usefulness and, not experimental in nature. 6. Is not duplicative with respect to other services being provided to the member. 7. Is not solely for the convenience of the member, the member's family or a provider. 8. With respect to prior authorization of a service and to other prospective coverage determinations made by the DHS, Is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member. 9. Is the most appropriate level of service that can safely and effectively be provided to the member. Claims where the provider fails to maintain records for purpose of substantiating appropriateness and necessity of services which are the subject of claims may be denied. A provider will be reimbursed only for services that are appropriate and medically necessary for the condition of the member. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 101.03(96m) § 106.02(5) § 101.03(103) § 106.02(9)(a) § 106.02(9)(b) §106.02(9)(g) § 107.03(5) § 106.02(9)e § 107.01 § 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
Provider submitted claim(s) for inpatient services when the member did not meet the appropriate inpatient criteria.	A member is considered either an inpatient or outpatient but cannot be both. A member is considered an inpatient when the member is admitted to the hospital as an inpatient and meets one of the following criteria: (1) is counted in the midnight census (2) is a same day admission and discharge patient (3) who dies before the midnight census. If an event results in the member not meeting one of the criteria, the inpatient service is non-covered. The DHS was unable to verify the actual provision of the Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 107.08(3)(c)3 § 106.02(5) § 101.03(96m) § 106.02(4) § 101.03(2) § 106.02(2) § 108.02(9) § 107.01		§ 49.45(2)(a)10 § 49.45(3)(f)
Provider submitted claim(s) for inpatient hospital institution for mental disease (IMD) services when the member did not meet the appropriate inpatient criteria.	A member is considered either an inpatient or outpatient but cannot be both. A member is considered an inpatient when the member is admitted to the hospital IMD as an inpatient and meets one of the following criteria: (1) is counted in the midnight census (2) is a same day admission and discharge patient (3) who dies before the midnight census. If an event results in the member not meeting one of the criteria, the inpatient service is non-covered. The DHS was unable to verify the actual provision of the Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 107.08(3)(c)3 § 107.13(1)(f)(4) § 107.13(1)(f)(8) § 101.03(96m) § 106.02(2) § 106.02(4) § 106.02(5) § 101.03(2) § 107.01 § 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: WRONG PROCEDURE CODE

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The procedure code submitted for reimbursement is not supported by the documentation submitted by the provider.	A provider is required to use applicable procedure codes for identifying services billed on the claim. The provider was reimbursed for code [XXX]. The documentation supports code [XXX]. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.03(2) § 106.02(9)(c)1 § 106.02(2) § 108.02(9) § 107.01	45 CFR§162.1000 45 CFR§162.1002	§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: OTHER INSURANCE PAYMENT

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider submitted documentation showing other insurance paid for this service; however, the other insurance payment shown on the documentation does not match the other insurance amount submitted and applied to the Medicaid claim.	Provider shall accurately identify the amount of the benefit payment from medicare, other health care plan or other third party payer on or with the bill to Medicaid. The amount of the medicare, health care plan or other third party payer reimbursement shall reduce the MA payment amount.The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.03(7)(c) § 106.02(9)(e) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10
The provider submitted documentation showing other insurance paid for this service; however, the other insurance indicator used on the MA claim indicated other insurance was not billed, and the other insurance was not applied to the Medicaid claim.	Provider shall accurately identify the amount of the benefit payment from medicare, other health care plan or other third party payer on or with the bill to Medicaid. The amount of the medicare, health care plan or other third party payer reimbursement shall reduce the MA payment amount. The provider entered other insurance indicator "OI-Y" on the claim, which indicates that other insurance was not billed, and the other insurance payment was not applied. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.03(7)(c) § 106.02(9)(e) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10
At the time of service, the member was covered by other insurance; however, there was no documentation in the member's file from the other insurance for this	Providers must retain all evidence of claims for reimbursement, settlements and denials resulting from claims submitted to other payers. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the	§ 106.02(9)(d) § 106.03(7)(f) § 106.03(7)(b)		§ 49.45(3)(f) § 49.45(2)(a)10

service.	accuracy of the claim.	§ 106.02(9)(e) § 107.01 § 108.02(9)		

FINDING: MEDICARE PAYMENT

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider submitted documentation showing Medicare paid for this service; however, the Medicare payment information shown on the documentation does not match the Medicare amount submitted on the Medicaid claim.	Provider shall accurately identify the amount of the benefit payment from medicare, other health care plan or other third party payer on or with the bill to Medicaid. The amount of the medicare, health care plan or other third party payer reimbursement shall reduce the MA payment amount. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.03(7)(c) § 107.02(1)(b) § 106.02(9)(e) § 106.03(7)(b) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10
The provider did not show the claim was billed to and denied by Medicare before billing Wisconsin Medicaid.	Wisconsin Medicaid is the payer of last resort. The provider is required to bill other insurance, including Medicare, prior to billing Medicaid. The provider must retain records showing proof of denial and submit them to the DHS upon request. The provider did not submit the requested records to the DHS. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.02(9)(c)2. § 106.02(9)(d)2. § 106.02(9)(e)1 § 106.03(7) § 106.03(6) § 107.01 § 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f) § 49.46(2)(c)

FINDING: TPL NOT PROPERLY BILLED

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider did not properly seek payment from other insurance.	Provider shall properly seek payment for the services provided to an Medicaid recipient from medicare or other eligible health care plan if the recipient is eligible for services under medicare or the other health care plan. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.03(7)(a)2 § 106.03(7)(b) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10
The provider did not properly seek payment from Medicare.	Provider shall properly seek payment for the services provided to an Medicaid recipient from medicare or other eligible health care plan if the recipient is eligible for services under medicare or the other health care plan. The Department was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.03(7)(a)2 § 106.03(7)(i) § 106.03(7)(b) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10

FINDING: LACK OF DOCUMENTATION

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
No documentation provided for the MA claim(s).	The provider must retain records for a period of not less than five years and must submit them to the DHS upon request. The provider did not submit the requested records to the DHS. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.02(9)(a) § 106.02(9)(e) § 106.02(9)(f) § 106.02(9)(g) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10 § 49.45(2)(b)4

FINDING: INCOMPLETE DOCUMENTATION

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider did not submit one or more documents required for the claim.	The provider must retain records for a period of not less than five years and must submit them to the DHS upon request. The provider did not submit the required records to the DHS. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.02(9)(a) § 106.02(9)(e) § 106.02(9)(f) § 106.02(9)(g) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10 § 49.45(2)(b)4
The order was not signed by a prescriber.	A prescription or order shall be in writing and shall include the prescriber's signature. Documentation submitted did not contain a prescriber's signature. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 107.02(2m)(b) § 106.02(9)(a) § 107.01 § 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: LACK OF M.D. ORDERS

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider was unable to produce a prescriber's order for a service that requires a prescriber's order.	All diagnostic services are required to be ordered by a prescriber. The provider must retain a record of this order for a period of not less than five years and must submit it to the DHS upon request. The provider did not submit the requested record to the DHS. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 107.08(4)(a)6. § 107.02(2m) § 107.25(2)(a) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.46(2)(a)4 § 49.45(2)(a)10

FINDING: DUPLICATE BILLING

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider billed and was paid for the same service to the same member more than one time. This service was already billed and paid on a separate claim.	A provider may not be reimbursed more than one time for the same service. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 101.03(96m)(b) § 106.04(5)(a) § 106.02(9)(e) § 106.03(2) § 106.02(9)(a) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10

FINDING: NON-COVERED SERVICES

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The hospital or hospital IMD performed a non-covered inpatient sterilization procedure.	Sterilization is covered only if: (1) The individual is at least 21 years old at the time consent is obtained; (2) The individual has not been declared mentally incompetent by a federal, state or local court of competent jurisdiction to consent to sterilization; (3) The individual has voluntarily given consent in accordance with all the requirements prescribed in DHS 107.06(3)(a)4 and DHS 107.06(3)(d); and (4) At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 107.08(3)(a)1. § 107.06 (3) § 106.02(9) § 106.02(2) § 107.13(1)(e)2 § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10
The hospital or hospital IMD billed for non-covered outpatient hospital services.	The following limitations apply to hospital outpatient services: (1) For services provided by a hospital on an outpatient basis, the same requirements shall apply to the hospital as apply to MA-certified non-hospital providers performing the same services; (2) Outpatient services performed outside the hospital facility may not be reimbursed as hospital outpatient services; (3) All covered outpatient services provided during a calendar day shall be included as one outpatient visit. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 107.08(3)(b) § 107.13(1)(e)2 § 108.02(9) § 107.01		§ 49.45(3)(f) § 49.45(2)(a)10
The hospital or hospital IMD provided a non-covered service.	For provision of inpatient psychiatric care by a general hospital as well as hospital IMD, these services are non-covered services: The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim. 1. Activities which are primarily diversional in nature such as services which act as social or recreational outlets to the member; 2. Mild tranquilizers or sedatives provided solely for the purpose of relieving the member's anxiety or insomnia; 3. Consultation with other providers about the member's care; 4. Conditional leave, convalescent leave or transfer days from psychiatric hospitals for members under the age of 21; 5. Psychotherapy or AODA treatment services when separately billed and performed by masters level therapists or AODA counsellors certified under s. DHS 105.22 or 105.23; 6. Group therapy services or medication management for hospital inpatients whether separately billed by an IMD hospital or by any other provider as an outpatient claim for professional services; 7. Court appearances, except when necessary to defend against commitment; and 8. Inpatient services for members between the ages of 21 and 64 when provided by a hospital IMD, except that services may be provided to a 21 year old resident of a hospital IMD if the person was a resident of the institution immediately prior to turning 21 and continues to be a resident after turning 21. A hospital IMD patient who is 21 to 64 years of age may be eligible for MA benefits while on convalescent leave from a hospital IMD. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 107.08(4)(g) § 107.13(1)(f) § 106.02(2) § 106.02(9) § 108.02(9) § 107.01		§ 49.45(3)(f) § 49.45(2)(a)10
The hospital or hospital IMD was reimbursed for a claim that was submitted prior to the day following the last date of service.	A claim may not be submitted by a hospital for a member who is a hospital inpatient until the day following the last date of service for which reimbursement is claimed. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.03(3)(a) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10
The hospital or hosital IMD billed for services that are non-covered hospital services.	The following services are not covered hospital services: 1. Unnecessary or inappropriate inpatient admissions or portions of a stay; 2. Hospitalizations or portions of hospitalizations disallowed by the Peer Review Organization (PRO); 3. Hospitalizations either for or resulting in surgeries which the DHS views as experimental due to questionable or unproven medical effectiveness;	§ 107.13(1)(e) § 107.08(4)(a) § 107.08(4)(b) § 107.08(4)(c) § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10

	experimental due to questionable or unproven medical effectiveness; 4. Inpatient services and outpatient services for the same patient on the same date of service unless the patient is admitted to a hospital other than the facility providing the outpatient care; 5. Hospital admissions on Friday or Saturday, except for emergencies, accident or accident care and obstetrical cases, unless the hospital can demonstrate to the satisfaction of the DHS that the hospital provides all of its services 7 days a week; and 6. Hospital laboratory, diagnostic, radiology and imaging tests not ordered by a prescriber, except in emergencies. Neither MA nor the member may be held responsible for charges or services listed above except that a member may be billed for charges if notified in writing in advance of the hospital stay that the service was a non-covered service. If hospital services are no longer medically necessary and an appropriate alternative care setting is available but the member refuses discharge, the member may be billed for continued services if they receive written notification prior to the time medically unnecessary services are provided. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 107.01		
The hospital or hospital IMD billed for professional services that are not covered as part of a hospital inpatient claim.	The professional services listed under DHS 107.08(4)(d) are not covered as part of a hospital inpatient claim but shall be billed by an appropriately certified MA provider. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 107.08(4)(d) § 107.13(1)(e) § 107.01 § 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10
The hospital IMD billed for professional services that are not covered as part of an hospital IMD claim.	In addition to meeting the conditions for provision of services listed under DHS 107.08(4), including separate billing, the following conditions apply to professional services provided to hospital IMD inpatients: 1. Diagnostic interviews with the member's immediate family members shall be covered services. 2. The limitations specified in DHS 107.08(3) 3. Electroconvulsive therapy shall be a covered service only when provided by a certified psychiatrist in a hospital setting. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 107.13(1)(e) § 107.08(4) § 108.02(9) § 107.01		§ 49.45(2)(a)10. § 49.45(3)(f)

FINDING: INCORRECT DIAGNOSIS RELATED GROUP (DRG) CODE

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
Documentation provided does not demonstrate an accurate claim. The DRG code billed by the provider is not supported by the documentation.	Claims must be accurate and complete using diagnosis, place of service, type of service, procedure codes and other information specified by the DHS under s. DHS 108.02 (4) for identifying services billed on the claim. Unnecessary or inappropriate inpatient admissions or portions of a stay; are non-covered hospital services. The DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ 106.03(1)(a) § 106.03(2) § 108.02(4) § 107.08(4)(a)1. § 106.02(9) § 106.02(2) § 106.02(4) § 106.02(5) § 107.01 § 108.02(9)	45 CFR 162.1000 45 CFR 162.1002(c)	§ 49.45(2)(a)10 § 49.45(3)(f)